# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

C9102

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

**1. PLACE OF DEATH:**

County: Harford

City or town: Havre De Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Months

Hospital, institution, or street address where death occurred: S. Market St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Elizabeth Abrahams

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: John J Abrahams Sr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 24, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 3 | 6 | ..... hrs. ..... min. |

9. Birthplace: Easton, Talbot Co., Md

(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER 12. Name: John T. Bartlett

13. Birthplace: Talbot Co., Md.

MOTHER 14. Maiden name: Rebecca Bartlett

15. Birthplace: Md.

16. Informant: John J. Abrahams

Address: Port Deposit, Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1947 (month) (day) (year)

Cemetery or crematory: Hopewell

Location: Port Deposit, Md. Rural

18. Funeral director: Lee A. Catterton

Address: Perryville, Md.

19. Oct. 31 1947 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30 1947, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1947, to Oct 30 1947

and that I last saw ... alive on Oct 30 1947

| Immediate cause of death | DURATION |
|---|---|
| Acute Pulmonary Congestion | |
| Due to Chronic Interstitial Nephritis | |
| Due to Arteriosclerosis | |
| Due to Chronic Myocarditis | |
| Other conditions Terminal | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles J. Foley M.D.

M. D. or other

Address: Havre de Grace Md. Date signed 10/31/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

94a

BC 09103

Reg. Dist. No. 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County: Harford

City or town: Aberdeen, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead On Arrival

Hospital, Institution, or street address where death occurred:
Ordnance School, Aberdeen Proving Ground, Maryland.

How long in hospital or institution? DOA

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1506 Eutaw Street.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

**3. (a) FULL NAME**

Blocker, Jay N.

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife: ----

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 30 July 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 2 | 9 | hrs. min. |

9. Birthplace: Carlisle, Penna.
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: United States Army

FATHER 12. Name: Monte C. Blocker

13. Birthplace: Carlisle, Penna.

MOTHER 14. Maiden name: Sophia A. Norris

15. Birthplace: Carlisle, Penna.

16. Informant: Tec/4 Alfred Pezzella

Address: Ord School, A.P.G. Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Oct 11 1947 (month) (day) (year)

Cemetery or crematory: J. K. Shulenberger

Location: Carlisle Pa

18. Funeral director: Howard L. McComas

Address: Abingdon Maryland

19. Oct. 15 1947 (Date rec'd by registrar) Registrar: Reggie T. Riley

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 October 1947, at DOA M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dead On Arrival 19 to 19

and that I last saw h alive on 19

| Immediate cause of death | Coronary Occlusion | DURATION |
|---|---|---|
| | | |
| Due to | | |
| Due to | | |
| Other conditions | | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Coronary Occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

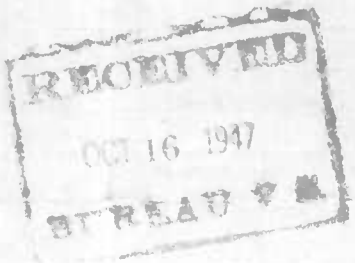
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lawrence Buchan, M.D. M. D. or other

Address: Station Hospital, A.P.G.Md. Date signed: 9 Oct 47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OCT 16 1947
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09104

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

**1. PLACE OF DEATH:**

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs

Hospital, Institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 5 hrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Abingdon

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** David N. Bowman

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 18, 1873

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 2 | 18 | ..... hrs. ..... min. |

9. Birthplace Harford Co. Maryland

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER

12. Name John Bowman

13. Birthplace Harford Co. Maryland

MOTHER

14. Maiden name Rebecca Bowman

15. Birthplace Harford Co. Maryland

16. Informant Mrs. Mary E. Turner

Address Edgewood Heights Md.

17. Burial (Burial, cremation, removal. Which?) Date thereof 10 18 47 (month) (day) (year)

Cemetery or crematory Rock Run

Location Harford Co. Md.

18. Funeral director H. S. Bailey

Address Darlington Md.

19. Oct. 18 1947 (Date rec'd by registrar) G. L. Lemmon Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH October 18, 1947 at 4 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 18 1947 to date Oct 18 1947

and that I last saw h alive on Oct 18 1947

| Immediate cause of death | DURATION |
|---|---|
| Coronary heart disease | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John F. Nogueira MD M. D. or other

Address Aberdeen Md. Date signed 10/18/47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

69510

94a

Reg. Diat. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

**1. PLACE OF DEATH:**
County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, institution, or street address where death occurred: Mt Calvary Road.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mt. Calvary Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** Robert Franklin Bowser

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6.(b) Name of ~~husband or~~ wife Caroline Monk
6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1887

8. AGE: Years 60 | Months 7 | Days | If less than one day ... hrs. ... min.

9. Birthplace Aberdeen Harford Co, Md.
(Town, county, and state)

10. Usual occupation Farm worker

11. Industry or business

FATHER
12. Name Josepfe Bowser
13. Birthplace Aberdeen, Md

MOTHER
14. Maiden name Cemelia Christy
15. Birthplace Aberdeen Md.

16. Informant Mrs. Robert F. Bowser
Address Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31 1947 (month) (day) (year)
Cemetery or crematory Union M. E.
Location Near Aberdeen.

18. Funeral director Henry Farring & Sons
Address Aberdeen Md.

19. Oct 31 1947 (Date rec'd by registrar) Nellie F. Riley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27th 1947 at 11:45a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/27 1947 to 10/27 1947 and that I last saw h.i.m. alive on 10/27 1947

| | DURATION |
|---|---|
| Immediate cause of death Myocardial Infarction | Terminal |
| Due to Coronary Arteriosclerosis | 2 years |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE Peter V. Robinson, M.D.
M. D. or other
Address Aberdeen, Md. Date signed 10/30/47

11

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93e

09105

## CERTIFICATE OF DEATH

Reg. Diat. No. 163

**1. PLACE OF DEATH:**
County: Harford
City or town: Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 82 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Jarrettsville R 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

**3. (a) FULL NAME:** HENRY EMRICK

**3. (b) Social Security Number:** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6.(b) Name of husband or wife: Fannie Kate McCleary
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 19 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 6 | 25 | ...hrs. ...min. |

9. Birthplace: Rocks Harford Co Md. (Town, county, and state)
10. Usual occupation: Lawyer
11. Industry or business: Retired
FATHER 12. Name: John Emrick
13. Birthplace: Germany
MOTHER 14. Maiden name: Catherine Hess
15. Birthplace: Germany
16. Informant: George Emrick
Address: Rocks Rd Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 17, 1947 (month) (day) (year)
Cemetery or crematory: Goodwill
Location: Fallston Md
18. Funeral director: Clark Martin County
Address: Jarrettsville Md.
19. Oct 17 1947 Thomas R. Brown
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 OCTOBER 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 1947 to 14 OCT. 1947 and that I last saw h.m alive on 14 OCTOBER 1947

Immediate cause of death: MYPOSTATIC PNEUMONIA — DURATION: 2 DAYS
Due to: CONGESTIVE HEART FAILURE — 2 YEARS
Due to: ARTERIOSCLEROSIS — 82 YEARS
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: H. P. Sidwell M.D.
M. D. or other
Address: Bel Air Md. Date signed: 14 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09106

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County: Harford

City or town: Magnolia (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Months

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md County: Harford

City or town: Magnolia (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Robert Price Ferrell

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6.(b) Name of husband or wife: Elizabeth Maxwell Ferrell 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 29-1882

8. AGE: Years 65 Months Days If less than one day hrs. min.

9. Birthplace: Montvale, Va (Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business

FATHER 12. Name: Edward R Ferrell

13. Birthplace: Va

MOTHER 14. Maiden name: Ida Kent

15. Birthplace: Va

16. Informant: Mrs Elizabeth M Ferrell

Address: Magnolia, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14/47 (month) (day) (year)

Cemetery or crematory: Presbyterian

Location: Churchville, Md

18. Funeral director: Joseph T Foster

Address: Bel Air, Md

19. 10/13/47 Priscilla Fawcett Registrar (Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 12 1947, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Coronary Occlusion | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J H Lammey M.D. M. D. or other

Address: Aberdeen, Md Date signed: 10/12/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

932 BC 09107 187

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

**1. PLACE OF DEATH:**
County: Harford
City or town: Harford Convalescent Home
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? Jan 29, 1947

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: ~~Harf~~ Baltimore City
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. 1034 N. Milton Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Charles Gabriel

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Madeline M. Gabriel
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): March - 3 - 1872

8. AGE: Years: 75 Months: 7 Days: 12 If less than one day: hrs. min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual occupation:
11. Industry or business: Retired
FATHER 12. Name: Unknown
13. Birthplace: "
MOTHER 14. Maiden name: "
15. Birthplace: "
16. Informant: Albert M. Gabriel
Address: 1034 N. Milton Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 - 18 - 47 (month) (day) (year)
Cemetery or crematory: Parkwood Cem
Location: Taylor Ave
18. Funeral director: John C. Miller Inc
Address: 2435 E Oliver St
19. Oct 16 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 15 1947, at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1947, to Oct. 15 1947, and that I last saw h[illegible] alive on Oct 14 1947.

Immediate cause of death: CEREBRAL HEMORRHAGE — DURATION: 5 da
Due to:
Due to:
Other conditions: Chr. Cardio-Vascular Disease With Hypertension — 5
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hedson M. D. or other
Address: Forest Hill Md Date signed: 10/15/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

## CERTIFICATE OF DEATH

09108

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-1

**1. PLACE OF DEATH:**
County Harford
City or town Chestnut Hill Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days 5
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Harford
City or town Chestnut Hill Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** James E Grover

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Widow |

6.(b) Name of husband or wife Francena Gordon
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22 / 1882

8. AGE: Years 65 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Co., Md
(Town, county, and state)

10. Usual occupation Labor & Farm work

11. Industry or business

FATHER
12. Name David W Grover
13. Birthplace Harford Co., Md

MOTHER
14. Maiden name Elizabeth B Brown
15. Birthplace Harford Co., Md

16. Informant Charles F. Wagner
Address Forest Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3 / 1947 (month) (day) (year)

Cemetery or crematory Union Chapel
Location Harford Co, Md

18. Funeral director Joseph T Foster
Address Bel Air, Md.

19. 10 / 2 / 19 47 (Date rec'd by registrar) Priscilla Fonwood Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 19 47, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Coronary occlusion | — |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Gerald C Palmer M.D.
Acting Deputy Medical Examiner
Harford County
M. D. or other

Address Bel Air Md. Date signed 10/1/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d 09109

Reg. Dist. No. 181

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Virginia County Fairfax
City or town Lorton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Jennie Bell HARRISON

**3.(b) Social Security Number**

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Charles M. Harrison
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan 19 1871

8. AGE: Years 76 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Fairfax Co. Va (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Don't Know
13. Birthplace

MOTHER
14. Maiden name: Don't Know
15. Birthplace

16. Informant: Robert Harrison
Address: 9 Aberdeen Ave, Aberdeen Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 30 - 1947 (month) (day) (year)
Cemetery or crematory
Location Oscoquan Va
18. Funeral director: King Funeral Home
Address Aberdeen Md
19. Oct. 30 1947 (Date rec'd by registrar) Nellie H. Riley Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct. 29 1947 at 5:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

| | DURATION |
|---|---|
| Immediate cause of death: CEREBRAL HEMORRHAGE | |
| Due to: ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. W. Lamer M.D.
Dep. Med. Examiner M. D. or other
Address Aberdeen, Md. Date signed 10/29/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161a

09110

## CERTIFICATE OF DEATH

Reg. Diat. No. 185

**1. PLACE OF DEATH:**

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Outside Port Deposit Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Baby Boy Hash William Melvin

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | newborn |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 30th 47

8. AGE: Years | Months | Days | If less than one day: 8 hrs. 40 min.

9. Birthplace Havre de Grace Md. (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Kyle Hash

13. Birthplace N. C.

MOTHER 14. Maiden name Ina Roberts

15. Birthplace N. C.

16. Informant Kyle Hash

Address Port Deposit Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2 1947 (month) (day) (year)

Cemetery or crematory Hopewell

Location Port Deposit Md.

18. Funeral director J. C. Tyson.

Address Rising Sun Md.

19. Oct. 1 1947 C. L. Lewis M.D. Registrar

(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH October 1st 1947 at 3 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30th 1947 to Oct 1st 1947

and that I last saw him alive on Sept 30th 1947

Immediate cause of death Pulmonary atelectasis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Noguera M.D. M. D. or other

Address Harford Memorial Hosp. Date signed 10/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93e

09111

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

**1. PLACE OF DEATH:**
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 19 days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre De Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 667 Green St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Mrs. Margaret M. Hines

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | |

6.(b) Name of husband or wife George W. Hines
6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) December 10, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 10 | 14 | ....hrs. ....min. |

9. Birthplace Port Deposit, Cecil Co., Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Henry Whitelock
13. Birthplace Cecil Co., Md.

MOTHER
14. Maiden name Margaret Mc Mullen
15. Birthplace Cecil Co., Md.

16. Informant G. W. Hines
Address 667 Green St., Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 26, 1947 (month) (day) (year)
Cemetery or crematory Hopewell
Location Port Deposit, Md.
18. Funeral director Lee A. Patterson & Son
Address Perryville, Md.
19. Oct. 25 47 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH October 24 47 19 45 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 '47 19 to Oct. 24 19 47 and that I last saw h.. alive on Oct. 23 '47 19

| Immediate cause of death | DURATION |
|---|---|
| Congestive heart failure | |
| Due to | |
| Due to | |
| Other conditions Severe secondary anemia | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John V. Noguera M.D. M. D. or other
Address Harford Mem. Hospital Date signed 10/24/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

176c

## CERTIFICATE OF DEATH

09112 181

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

**1. PLACE OF DEATH:**
County: Harford
City or town: Berryman (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Visiting
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No.: 226 Camden Ave. (If rural, give LOCATION)
2.(a) If veteran, name war: World War 2

**3.(a) FULL NAME:** James Phillip Holden

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 19, 1924

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 7 | | hrs. min. |

9. Birthplace: Salisbury, Md. (Town, county, and state)
10. Usual occupation: Sailor U.S. Randolph
11. Industry or business: U.S. Navy

FATHER
12. Name: Henry Harvey Holden
13. Birthplace: Belgium Mich.

MOTHER
14. Maiden name: Nova B. Wingis
15. Birthplace: La Grange, Ind.

16. Informant: Henry H. Holden
Address: 226 Camden Ave., Salisbury

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Md.
18. Funeral director: Hollowell & Co. Walter R. Holl
Address: Salisbury Maryland
19. Oct 19 1947 (Date rec'd by registrar) Willie H. Riley Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 18 1947 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Fracture cervicle vertebra — DURATION: Instant
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 10/18/47
Where did injury occur? Berryman (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?): Highway
Nature of injury: Cracked Tree Injured at work? No

23. SIGNATURE: Arnold C Palmer M.D.
Acting Deputy Medical Examiner
Harford County M. D. or Other
Address: Bel Air, Md. Date signed: 10/18/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09113

## CERTIFICATE OF DEATH 93d

Reg. Diat. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

**1. PLACE OF DEATH:**

County: Harford

City or town: Bel Air Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Rural - Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Kalmia

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** J. C. Bosley James

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6.(b) Name of husband or wife: Marian Andrews

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 25 1873

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 9 | | ..... hrs. ..... min. |

9. Birthplace: Farmer Harford Co. Md

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Charles H. James

13. Birthplace: Harford Co Md

MOTHER

14. Maiden name: Martin Cook

15. Birthplace: Harford Co. Md

16. Informant: Mrs. Frank Mahan

Address: Aberdeen Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 11-1947 (month) (day) (year)

Cemetery or crematory: Smith Chapel

Location: Churchville

18. Funeral director: Henry Tarring Sons

Address: Aberdeen Md

19. 10/9 (Date rec'd by registrar) 19 47 Priscilla Harwood Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 19 47, at 6:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7 19 47, to Oct 9 19 47 and that I last saw b. alive on Oct 7 19 47

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | Sudden |
| Due to | |
| Due to | |
| Other conditions: Chr. Hypertensive Cardio-Vascular Disease | 5 |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Willard P. Judson M. D. or other

Address: Forest Hill Md Date signed 10-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

164c

69511

Reg. Dist. No. 182

**1. PLACE OF DEATH:**

County: Harford

City or town: Darlington, Md. RD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Darlington Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1.

**3.(a) FULL NAME:** ARTHUR F. JOINES

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Florence Joines

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Sept 28-1896.

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 0 | 14 | ...hrs. ...min. |

9. Birthplace: Ash Co. N.C.

(Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business: Baintridge, Md.

FATHER

12. Name: Rufus Joines

13. Birthplace: Alleghany Co. N.C.

MOTHER

14. Maiden name: Virginia Osborn

15. Birthplace: Grayson Creek, Va.

16. Informant: Joseph F. Joines

Address: Darlington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14 1947 (month) (day) (year)

Cemetery or crematory: Highland Cem.

Location: Street, Md.

18. Funeral director: Hubert F. Jenkins

Address: Delta, Pa.

19. Oct. 14, 1947 (Date rec'd by registrar) M. G. Kirk Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12 1947 at 8: A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h...alive on ...19...

| Immediate cause of death | DURATION |
|---|---|
| GUNSHOT WOUND OF HEAD | |
| LEFT SIDE | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: SUICIDE Date of: 10/12/47

Where did injury occur? BERKLEY (City or town) HARFORD (County) Md. (State)

Injured at home, farm, industry, public place (where?): HOME

Means of injury: SHOTGUN - 12 Ga. Injured at work? NO

23. SIGNATURE: J. W. Lawney M.D.

Deputy Medical Examiner

Address: Aberdeen, Md. Date signed: 10/12/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09114

93d

## CERTIFICATE OF DEATH

Reg. Diat. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

**1. PLACE OF DEATH:**

County Harford

City or town Harford Furnace Bel Air R D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Harford Furnace, Bel Air R D

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Ann T. Lynch

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife David J. Lynch

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 4 1867

8. AGE: Years 80 | Months 4 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Patrick Moran

13. Birthplace Ireland

MOTHER 14. Maiden name Catherine Clark

15. Birthplace Ireland

16. Informant Miss Katherine Lynch

Address Harford Furnace, Bel Air Rd. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 9, 1947 (month) (day) (year)

Cemetery or crematory St. Francis

Location Abingdon Maryland

18. Funeral director Howard F. McComas

Address Abingdon Maryland

19. 10/8/1947 (Date rec'd by registrar) Marie M. Mouldale Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1947, at 7:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Oct 5 1947

and that I last saw h[illegible] alive on Oct 5 1947

| Immediate cause of death | DURATION |
|---|---|
| Arteriosclerosis | |
| Chronic Myocarditis | |
| Due to Acute Bronchitis | |
| Pneumonia congestion | |
| Due to Effusion of lungs | |
| Other conditions Pneumonia | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles J. Foley M.D.
M. D. or other

Address Harford Furnace Md Date signed 10/7/47


OCT 13 1947

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

69512

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

**1. PLACE OF DEATH:**
County Harford
City or town Rural Havre de Grace, R.D. #1.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Home
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Harford
City or town Rural, Havre de Grace, R.D. #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** Julia Craig Martin

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: Wiley P. Martin
6.(c) If alive, give age —
7. Birth date of deceased (mo., day, yr.): May 31, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 4 | 28 | hrs. min. |

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business:
FATHER 12. Name: Joseph L. Caldwell
13. Birthplace: Va
MOTHER 14. Maiden name: Sarah Carper
15. Birthplace: Va.
16. Informant: Mr. J. J. Bascom Martin
Address: Havre de Grace R.D. #1 Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31, 1947 (month) (day) (year)
Cemetery or crematory: Harmony Ch. Yard
Location: Harford Co. Md.
18. Funeral director: P. Madison Mitchell
Address: Havre de Grace Md.
19. Oct. 29 1947 (Date rec'd by registrar) Bertha B. Knight Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28 1947, at 11A., M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1947, to Oct 28 1947
and that I last saw her alive on Oct 10 1947

| Immediate cause of death | DURATION |
|---|---|
| Coronary Occlusion | 6 Mo. |
| Due to: Natural | |
| Due to: Hypertention | |
| Other conditions: Cerebral Sclerosis | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. P. Snodgrass M. D. or other
Address Darlington Md. Date signed 10/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09115

159

Reg. Dist. No. 18 S-

**1. PLACE OF DEATH:**

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 7 hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: ~~Havre de Grace~~ Darlington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Baby Girl McMullin

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | C. | Infant |

6.(b) Name of husband or wife

6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) October 11 - 1947

**8. AGE:** Years — | Months — | Days — | If less than one day: 6 hrs. 45 min.

9. Birthplace: Havre de Grace, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: —

FATHER

12. Name: Granville Hall

13. Birthplace: Harford Co. Md.

MOTHER

14. Maiden name: Evelyn Wilson

15. Birthplace: Maryland

16. Informant: Mrs. Wilson (grandmother)

Address: Darlington 1 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 12-47 (month) (day) (year)

Cemetery or crematory: Darlington - Mem

Location: Darlington - Md.

18. Funeral director: K. V. Bailey

Address: Darlington 1 Md.

19. Oct. 11 1947 (Date rec'd by registrar) Reg. A. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11th 1947 at 5 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 11/47 19... to Same 19...

and that I last saw h... alive on Same 19...

| Immediate cause of death | DURATION |
|---|---|
| Prematurity. | |
| Due to: Mother has pre-eclampsia and nephritic toxemia | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Baby delivered by Cesarean section Date of op. Oct. 11/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John F. Noguera M.D. M. D. or other

Address: Hartford Mem Hosp Date signed: Oct. 11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
OCT 15 1947

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

83b CB 09116

Reg. Diat. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County: Harford

City or town: Rural Bel Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md Ark Washington County: Garland

City or town: Prairie Grove Ark

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Margaret Ethel NOLAN

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | married |

6.(b) Name of husband or wife: James H. Nolan

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.): Oct 20 1886

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 11 | 22 | ....hrs. ....min. |

9. Birthplace: Fairmont Arkansas (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: W. W. Allen

13. Birthplace: Arkansas

MOTHER

14. Maiden name: Henrietta Reed

15. Birthplace: Arkansas

16. Informant: Mrs. James H. Nolan

Address: 18 Post Road Aberdeen Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 13 1947 (month) (day) (year)

Cemetery or crematory: Prairie Grove Ark

Location: Fayetteville Arkansas

18. Funeral director: Henry Taming Sons

Address: Aberdeen Md.

19. 10/13 1947 Priscilla Fawood

(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 12 1947, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5 1947 to Oct 12 1947 and that I last saw her alive on Oct. 12 1947

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Thrombosis | 36 hr. |
| Due to | |
| Due to | |
| Other conditions Cerebral Arterio-sclerosis (Include pregnancy within 3 months of death) | 14 yr. |

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill Md Date signed 10/12/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

516 K 09117

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

**1. PLACE OF DEATH:**
County HARFORD
City or town RURAL - JARRETTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State MARYLAND County HARFORD
City or town RURAL - JARRETTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. RURAL - FEDERAL HILL
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** ELI CLEVELAND REEDY

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6.(b) Name of husband or wife REBECCA JANE REEDY
6.(c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) JUNE 16, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 3 | 22 | hrs. min. |

9. Birthplace GRASSY CREEK - ASH CO., NC (Town, county, and state)
10. Usual occupation FARMER
11. Industry or business

FATHER
12. Name CALVIN REEDY
13. Birthplace NORTH CAROLINA

MOTHER
14. Maiden name ELLEN BLEVINS
15. Birthplace NORTH CAROLINA

16. Informant MRS NELLIE CALHOUN
Address HARRINGTON, DEL.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12 1947 (month) (day) (year)
Cemetery or crematory Bel-Air Burial Park
Location Bel-Air, Md
18. Funeral director Martin G. Kurtz
Address Jarrettsville, Md.
19. Oct. 11 1947 (Date rec'd by registrar) Thomas R. Brown Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1947 at 12:20 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to Oct. 9, 1947
and that I last saw h.i.w. alive on Oct. 8, 1947

| | DURATION |
|---|---|
| Immediate cause of death Bronchial pneumonia | 1 day |
| Due to Severe mal nutrition | |
| Due to Carcinoma of prostate gland with metastasis | 8 yrs. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of prostate gland Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles A. Neff M.D. M. D. or other
Address Street, Md. Date signed 10-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
OCT 13 1947
SCREAD

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e 09118

## CERTIFICATE OF DEATH

Reg. Diat. No. 185

**1. PLACE OF DEATH:**
County Harford
City or town Havre de Grace, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. 1
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** Johnna Helores Ringgold

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Negro | Infant |

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1946

8. AGE: Years 1 Months 3 Days If less than one day hrs. min.

9. Birthplace Havre de Grace, Md (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Lawrence Ringgold

13. Birthplace Oxford, Pa

MOTHER 14. Maiden name Geneva Brown

15. Birthplace Perryman, Maryland

16. Informant Mr. & Mrs. L. Ringgold

Address Havre de Grace R.F.D. 1, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-14-1947 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Aberdeen Maryland

18. Funeral director Elmer E. Pollock

Address 556 Lewis St. Havre de Grace

19. Oct. 14 1947 C. L. Lewis M.D. Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1947, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 7 1946 to Oct 11 1947; and that I last saw h alive on Oct 11 1947

| Immediate cause of death | DURATION |
|---|---|
| Congenital Malformation of Heart | |
| Due to | |
| Due to Cardiac Failure. | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wendell J. Talley M.D. M. D. or other

Address Havre de Grace Date signed 10/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


OCT 16
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 1a

09119

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

**1. PLACE OF DEATH:**

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 9 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9 Market St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME** Mrs. Mary L. Sanner

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | (Widowed) |

6.(b) Name of husband ~~or wife~~: Basil P. Sanner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 19, 1865

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 8 | | hrs. min. |

9. Birthplace: Stewartstown, Pa.

(Town, county, and state)

10. Usual occupation: At leisure

11. Industry or business:

FATHER 12. Name: Charles M. Dunwicke

13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: M. Elizabeth Reed

15. Birthplace: Pennsylvania

16. Informant: Mrs. Florence Ks Rexroth

Address: 9 Market St. Aberdeen

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15 1947 (month) (day) (year)

Cemetery ~~or crematory~~: Bakers

Location: Aberdeen, Md.

18. Funeral director: Henry Taxis & Sons

Address: Aberdeen, Md.

19. Oct. 14 1947 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1947 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3 1947 to Oct. 12 1947 and that I last saw her alive on Oct. 12-47 1947

| Immediate cause of death | DURATION |
|---|---|
| Uremic Coma | |
| Due to Chronic nephritis | |
| Generalized arteriosclerosis | |
| Due to Chronic myocarditis | |
| Arteriosclerotic gangrene left lower limb | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Mid-thigh amputation left leg Date of op. 10.6.47

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John F. Noguera MD M. D. or other

Address: Harford Mem Hosp Date signed 10-12-47

09120

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

**1. PLACE OF DEATH:**
County: Harford
City or town: Rural Aberdeen Md. R.D. #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Home
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Rural Aberdeen, Md. R.D. #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

**3.(a) FULL NAME:** Charles Elsworth Schultz

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Elizabeth Amelia Schultz
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Jan. 12, 1880

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 9 | 3 | — hrs. — min. |

9. Birthplace: Norfolk Conn. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Wm. F. Schultz
13. Birthplace: Germany

MOTHER
14. Maiden name: Abigal Parmalee
15. Birthplace: Conn.

16. Informant: Mrs. Elizabeth A. Schultz
Address: Aberdeen Md. R.D. #2

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 17, 1947 (month) (day) (year)

Cemetery or crematory: Winsted Conn.
Location:
18. Funeral director: R. Madison Mitchell
Address: Havre de Grace Md.

19. Oct. 16 19.47 (Date rec'd by registrar) Berta B. Knight Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 15 19.47, at 12-15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5 19.47, to Oct. 14 19.47 and that I last saw h... alive on Oct. 14 19.47

| Immediate cause of death | DURATION |
|---|---|
| Pneumonia | 5 Days |
| Due to: Fractured | |
| Due to: | |
| Other conditions: Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. V. Snodgrass M. D. or other
Address: Darlington Md. Date signed: 10/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09121

# CERTIFICATE OF DEATH

51 & X

Reg. Dist. No. 185

**1. PLACE OF DEATH:**

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 12 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Harford Cecil

City or town: Perryville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Elm St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Mr. William Schumm

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W. | (M) |

6.(b) Name of husband or wife: Bessie Schumm

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 31, 1877

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 70 | 4 | 3 | hrs. min. |

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Baker, Retired

11. Industry or business: Owner

FATHER 12. Name: Henry Schumm

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Germany

16. Informant: Bessie Schumm

Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 6, 1947 (month) (day) (year)

Cemetery or crematory: H opewell

Location: Port Deposit, Md. Rural

18. Funeral director: Wm A. Patterson & Son

Address: Perryville, Md.

19. Oct. 6 1947 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3rd 1947 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-21-47 19 to 10-3-47 19

and that I last saw him alive on 10-3-47 19

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Prostate with metastases | |
| Due to | |
| Due to | |
| Other conditions: Arteriosclerosis Mitral insufficiency | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John F. Noguera M.D. M. D. or other

Address: Harford Memorial Hospital Date signed 10/3/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

94a 09122

Reg. Dist. No. 185

**1. PLACE OF DEATH:**

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 Union St

(If rural, give LOCATION)

2.(a) If veteran, name war —

**3.(a) FULL NAME** John B. Sharp

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6.(b) Name of husband or wife Minerva E. Sharp Deceased (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 11 | 11 | ..... hrs. ..... min. |

9. Birthplace Canada (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Lucius Sharp

FATHER 13. Birthplace Canada

MOTHER 14. Maiden name Margaret Van Rhyke

MOTHER 15. Birthplace New York State

16. Informant Mrs. C.C. Sharp

Address Havre de Grace

17. Buried (Burial, cremation, or removal. Which?) Date thereof 10/31/47 (month) (day) (year)

Cemetery or crematory Mowen

Location Odenton Canada

18. Funeral director Pennington & Son

Address Havre de Grace

19. Oct 28 1947 (Date rec'd by registrar) G.L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1947, at 9:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1947 to Oct 27 1947

and that I last saw h— alive on Oct 27 1947

| Immediate cause of death | DURATION |
|---|---|
| Hypostatic Pneumonia | |
| Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other conditions Cardiac Failure | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Newton A. Talley M.D. M. D. or other

Address Havre de Grace Date signed 10/28/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

932 09123

# CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:
County Harford
City or town Jarrettsville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Jarrettsville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Laura Sydney Slade

3.(b) Social Security Number

4. Sex F.
5. Color or race W
6.(a) Single, married, widowed, or divorced Married
8.(b) Name of husband or wife James Isaac Slade
8.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) May 30, 1884
8. AGE: Years 63 Months 4 Days 9 If less than one day ____ hrs. ____ min.
9. Birthplace Jarrettsville Har. Co. Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER 12. Name Wm Lynch
13. Birthplace Jarrettsville, Md.
MOTHER 14. Maiden name Lottie Barber
15. Birthplace Jarrettsville Md
16. Informant J. Isaac Slade
Address Street, Md
17. Burial Date thereof Oct 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Jarrettsville
Location Jarrettsville Md
18. Funeral director Martin D. Kurtz
Address Jarrettsville, Md.
19. Oct 11 1947 Thomas R. Brown
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1947, at 1:00 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, 1945 to Oct. 9, 1947
and that I last saw her alive on Oct. 8, 1947

| | DURATION |
|---|---|
| Immediate cause of death Pulmonary edema | |
| Due to Heart failure | 3 mo. |
| Due to Hypertension & cardio vascular disease | 5 yrs. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles C. Heft M. D.
M. D. or other
Address Street, Md. Date signed 10-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09124

83a

B

## CERTIFICATE OF DEATH

Reg. Diat. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County: Harford

City or town: Aberdeen, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? seven and one half hrs (7½)

Hospital, institution, or street address where death occurred:
Station Hospital, Aberdeen Proving Ground, Md

How long in hospital or institution? 7½ hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Kentucky County: - - -

City or town: Ashland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1636 Hilton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

**3.(a) FULL NAME**

STARR, ROBERT L.

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Ruth Ann Starr

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 10 September 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | - | 29 | ..... hrs. ..... min. |

9. Birthplace: Silver City, New Mexico
(Town, county, and state)

10. Usual occupation: U. S. Army

11. Industry or business

FATHER
12. Name: Unk.
13. Birthplace: U. S.

MOTHER
14. Maiden name: Unk.
15. Birthplace: U. S.

16. Informant: Sgt. Herbert Dixson

Address: Aberdeen Proving Ground, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13, 1947 (month) (day) (year)

Cemetery or crematory: Post Cemetery

Location: Aberdeen Proving Ground Md

18. Funeral director: Howard R. McComas Funeral Home

Address: Abingdon Md.

19. Oct. 15 1947 (Date rec'd by registrar) Nellie H. Riley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 October 1947 at 1640 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9 October 1947, to 9 October 1947 and that I last saw him alive on 9 October 1947

| Immediate cause of death | DURATION |
|---|---|
| Sub-arachnoid hemorrhage. | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: None performed Date of op. .....

Autopsy results: None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Laurence Dickson Jr. M.D. (M. D. or other)

Address: Sta Hospital, APG, Md. Date signed .....


RECEIVED
16 1947

09125

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County: Harford
City or town: Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
County Home
How long in hospital or Institution? 10 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME** Charles Steward

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Widower |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec 5- 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 10 | 19 | hrs. min. |

9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: John Steward
13. Birthplace: Scotland

MOTHER
14. Maiden name: Mary Bannerman
15. Birthplace: Scotland

16. Informant: Clark Fitzpatrick
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 25 47 (month) (day) (year)
Cemetery or crematory: County Home
Location: Near Bel Air Md
18. Funeral director: Joseph I Foster
Address: Bel Air Md

19. 10/24 1947 Priscilla Forwood
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 24 1947, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1947 to Oct 24 1947 and that I last saw him alive on Oct 1 1947

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | Sudden |
| Due to: | |
| Due to: | |
| Other conditions: Ch. Cardio-Vascular Renal disease | 5 |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed: 10/24/47

corrected

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09126

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

**1. PLACE OF DEATH:**

County: Harford

City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Mem Hospital

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Edgewood (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Baby Boy Tiller

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W. | |

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1947 at 11 PM

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | 1 | 5 hrs. 30 min. |

9. Birthplace Van Bibber, Harford Cty. Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name Perry B Tiller

FATHER — 13. Birthplace Va.

MOTHER — 14. Maiden name Roxie Wampler

MOTHER — 15. Birthplace Va.

16. Informant Perry B. Tiller (Father)

Address Edgewood - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29 47 (month) (day) (year)

Cemetery or crematory Cokesbury

Location Abingdon - Md

18. Funeral director Hands & McComas

Address Abingdon - Md.

19. Oct. 29 1947 by G. L. Lewis M. D. Registrar

(Date rec'd by registrar) Havre de Grace

**MEDICAL CERTIFICATION**

20. DATE OF DEATH October 29th 1947 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28, 1947 to June 19 and that I last saw h[illegible] alive on Oct. 28, 1947

| Immediate cause of death | DURATION |
|---|---|
| Prematurity | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Nogueira M.D. M. D. or other

Address Harford Mem Hospital Date signed 10/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

09127

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

**1. PLACE OF DEATH:**
County: Harford
City or town: Kalmia R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred: Harford Convalescent Home
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Kalmia
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** David Wagner

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | widower |

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct 16, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 11 | 25 | ... hrs. ... min. |

9. Birthplace: Rocks, Harford Co. Md. (Town, county, and state)
10. Usual occupation: Granite Cutter
11. Industry or business: Retired

FATHER
12. Name: Jacob Wagner
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Tyre
15. Birthplace: Germany

16. Informant: Jacob Wagner
Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14 1947 (month) (day) (year)
Cemetery or crematory: North Bend
Location: Rocks, Md.

18. Funeral director: Martin G. Kurtz
Address: Jarrettsville, Md

19. Oct. 14 1947 (Date rec'd by registrar) Thomas R. Brown Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct - 11, 1947, at 12-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to Oct 11, 1947
and that I last saw h.i. alive on Oct. 10, 1947

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Edema | 3 days |
| Due to Heart failure | 2 mo. |
| Due to Hypertension & Arteriosclerosis | 1 yr. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Charles E. Wolf M.D. or other
Address: Street, Md Date signed: 10-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

09128

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

**1. PLACE OF DEATH:**
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 9 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Juniata
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Mr. William G. Whitney

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W. | (M) |

6.(b) Name of husband or wife –
6.(c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 8/9/1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 2 | 8 | hrs. a min. |

9. Birthplace Havre de Grace
(Town, county, and state)
10. Usual occupation Ice, Wood & Coal
11. Industry or business

FATHER
12. Name Wm. D. Whitney
13. Birthplace Havre de Grace

MOTHER
14. Maiden name Sarah E. Harwood
15. Birthplace Harford Co. Md.

16. Informant Mrs. H.C. Whitney
Address Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/20/47 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
18. Funeral director Cunningham & Son
Address Havre de Grace, Md.

19. Oct. 18 1947 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH October 17th 1947, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8-47 19.. to Oct. 17 19.47
and that I last saw h... in alive on Oct. 17-47 19..

| Immediate cause of death | DURATION |
|---|---|
| Uremia | |
| Anuria. Chronic nephritis | |
| Due to Urethral stricture & retention of urine | |
| Due to | |
| Other conditions Chronic myocarditis, Chronic decholuimi | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John F. Noguera M.D.
M. D. or other
Address Harford Mem. Hosp. Date signed 10/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09129

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 221 Bloomsbury
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** William F. Wisted

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Elizabeth Wisted
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 10 | 26 | ...hrs. ...min. |

9. Birthplace: Pottsville Pa.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business
FATHER 12. Name: James Wisted
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Mary Ann Conley
MOTHER 15. Birthplace: Penna.
16. Informant: Elizabeth Wisted (wife)
Address: 221 Bloomsbury H. de Grace
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/3/47 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Pottsville Pa.
18. Funeral director: R.C. Reiley
Address: Pottsville Pa.
19. 10-30 1947 (Date rec'd by registrar) A.L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30 1947, at 3a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 1947, to Oct 30 1947
and that I last saw h... alive on Oct 30 1947

| Immediate cause of death | DURATION |
|---|---|
| Acute Cerebral Coronary Thrombosis | |
| Due to: Hypertension | |
| Due to: | |
| Other conditions: Cerebral Edema | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R.C. Reiley Jr M.D.
M. D. or other
Address: Havre de Grace Md. Date signed 10/30/47